AGED AND DISABLED WAIVER
REQUEST FOR SERVICE LEVEL CHANGE

ADW PARTICIPANT INFORMATION:

Name: _____Birth date: ___/_____/_____ Medicaid # _____

Street Address: _____City: _____State: _____ Zip: _____

County: _____

Legal Representative, if applicable: _____Phone: _____

Participant/ Legal Representative Signature: _____

Current PAS Date: _____

AGENCY INFORMATION:

Agency Name: _____

Street Address: _____City: _____State: _____ Zip: _____

Phone: _____Fax: _____

_____

Participant/Legal Representative Signature Date

REQUIRED DATA MUST BE SUBMITTED WITH THIS FORM:
☐ A completed copy of this cover sheet with **original signatures**
☐ A narrative explaining the need for Service Level change.
☐ A statement from physician, nurse practitioner or physician's assistant explaining the need for Service Level change.
☐ Current ADW PAS.
☐ Current Service Plan with Personal Attendant Log
☐ Proposed PAL Update
☐ Any additional documentation that substantiates the request.

Send all required documents to: APS Healthcare, 100 Capitol Street, Suite 600, Charleston, WV 25301. Fax: 866-212-5053.